AUTHORIZATION FOR RELEASE OF INFORMATION

ND DEPARTMENT OF HUMAN SERVICES
LEGAL SERVICES
SFN 1059 (Rev. 01-2003)

PRIVACY STATEMENT: Disclosure of the social security number is voluntary and is requested for the purpose of accurate identification. Failure to disclose this information will not affect the release of information. The Department will not condition treatment on your agreement to authorize disclosure of your health information. The Department may, however, require that you authorize disclosure of your health information if needed to make a determination about your eligibility for benefits or enrollment in a Department health plan.

INSTRUCTIONS: Provide information as it existed when the service was provided.

Name of Client: (Last, First, Middle Initial)	Social Security Number:	Date of Birth:	
Street Address:	City:	State:	Zip Code:

CLIENT RELEASE AND SIGNATURE

1. **I Hereby Authorize:**			
Name of Person/Agency:			
Street Address:	City:	State:	Zip Code:
2. **To Release Information To:**			
Name of Person/Agency to Receive Information:			
Street Address:	City:	State:	Zip Code:
3. The Following Information Is Requested: (Be Specific)			
4. The Information Identified Above Will Be Used For: (Be Specific)			
5. This Authorization for Release of Information Consent Remains in Effect Until: (Date)			
OR: (Specific Event Terminating Operation of the Release)			
6. The Information Identified Above May be Transmitted by the Following Means: (Check all that apply) ☐ Written ☐ Verbal ☐ Audio ☐ Video ☐ Electronic ☐ All of the Preceding			

CLIENT CONSENT:

This authorization is voluntary and remains in effect until the above date or event, unless specifically revoked by written notice to the agency or person. Refer to the Notice of Privacy Practices for further description of revocation rights. Any information released prior to written revocation of this authorization shall not be a breach of confidentiality. A photocopy of this release is as effective as the original.

Signature of Client:	Date:
Signature of Parent/Guardian or Custodian (if needed and Relationship:)	Date:
Signature of Witness (if needed):	Date:

☐ **CHECK IF APPLICABLE - NOTICE TO WHOMEVER DISCLOSURE IS MADE CONCERNING ADDICTION RECORDS**
This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

NOTICE: Except for information subject to 42 CFR Part 2, information disclosed to another entity may potentially be redisclosed, in which case it may not be protected by state or federal law.

DISTRIBUTION:
- ☐ To agency/person from whom information is sought
- ☐ Requesting Agency
- ☐ Client
- ☐ Other